Updated July 2003

Prescription Advantage

Your Plan for Affordable Prescriptions

Application Form and Instructions

Administered by the Massachusetts Executive Office of Elder Affairs

1-800-AGE-INFO (1-800-243-4636) • www.800ageinfo.com
TTY 1-877-610-0241 (toll free) for the deaf and hard of hearing

July 2003

Prescription Advantage

Your Plan for Affordable Prescriptions

Thank you for your interest in Prescription Advantage. This booklet contains an overview of Prescription Advantage and an Application Form with instructions. It is important to read and understand all sections of this booklet before completing and submitting the Application Form. When your submitted Application Form is approved, you will be enrolled as a member of Prescription Advantage.

Overview

Prescription Advantage is a prescription drug insurance plan administered by the Commonwealth of Massachusetts. Prescription Advantage is available to all Massachusetts residents age 65 or older, as well as younger individuals with disabilities who meet income and employment guidelines.

Prescription Advantage members pay premiums, deductibles and co-payments based on their gross annual household income. The Rate Schedule Guide on page 3 lists premium, deductible and co-payment rates for Prescription Advantage effective October 1, 2003.

Prescription Advantage, unlike many other plans, places an annual out-of-pocket spending limit on the amount you pay toward your prescription drugs in deductible and co-payment amounts. Your annual out-of-pocket spending limit is based on your gross annual household income. The Rate Schedule Guide on page 3 lists the annual out-of-pocket spending limits for Prescription Advantage effective October 1, 2003.

Prescription Advantage covers most outpatient prescription drugs, including insulin and disposable insulin syringes with needles. The drugs on the formulary (the list of drugs available to members) are categorized into three levels: generic, brand-name drugs and additional brand-name drugs. Generic drugs have the lowest co-payment; additional brand-name drugs have the highest co-payment.

If you have any additional questions about Prescription Advantage, please call customer service Monday through Friday, 9 a.m. to 5 p.m. at:

1-800-AGE-INFO (1-800-243-4636), press “1”
TTY 1-877-610-0241 (toll free) for the deaf and hard of hearing

Joining Prescription Advantage

Who Can Join:

You may join Prescription Advantage if you are a Massachusetts resident and you are:

1. Age 65 or older; or
2. Under age 65, work 40 hours or fewer per month, or not at all, and meet income and disability guidelines.

Individuals receiving prescription drug benefits through Medicaid (MassHealth or CommonHealth) cannot join Prescription Advantage.

When You Can Join:

For those age 65 to 66:

You may join at any time before your 66th birthday. If you submit your application shortly before you turn 65, the Plan will hold your application and process it as of your 65th birthday. Your benefits will begin on the first day of the month following the complete processing of your application.

For those age 66 or older:

You may join Prescription Advantage only during the established open enrollment period each year. The next open enrollment is August 1 through August 31, 2003. If you join during this period your benefits will begin October 1, 2003. If you choose not to join during this period, you will have to wait until the next open enrollment period, and you may be assessed a surcharge upon joining.

Exceptions for individuals age 66 or older:

Those who meet one of the following conditions will be granted an exception to the rules above:

1. Recently moved to Massachusetts; or
2. Involuntarily lost health care coverage; or
3. Recently became ineligible for Medicaid.

If any of these circumstances apply to you, you have up to six months from the date that the circumstance occurred to submit an application. Your benefits will begin on the first day of the month following the complete processing of your application.

For those under age 65:

You may join at any time, however, you must work 40 hours or fewer per month, or not at all, and meet disability and income guidelines. Your benefits will begin on the first day of the month following the complete processing of your application.

Please note: ***All deadlines are determined by the date the Plan receives your application, NOT when it is post-marked. You should allow at least five business days and include the appropriate amount of additional postage for first class mail to arrive.***

PRESCRIPTION ADVANTAGE RATE SCHEDULE GUIDE

Effective October 1, 2003

This rate schedule is only a guide. You may refer to the chart below to estimate your premium, deductible and co-payment amounts with Prescription Advantage.

Co-Payments

There are three co-payment levels: Level 1 (Generic Drugs); Level 2 (Brand-Name Drugs); and Level 3 (Additional Brand-Name Drugs). Please refer to the chart below for the co-payment amounts you will pay at retail (up to a 30-day supply) or mail service (up to a 90-day supply).

Your Annual Out-Of-Pocket Spending Limit

Out-of-Pocket Expenses = Your Deductible + Co-Payments made from July 1 (or start of membership) through June 30 each year

Single or Married with only one spouse in the plan

When your out-of-pocket expenses reach either $2,000 or 10% of your gross annual household income, whichever is less, you will no longer be required to pay co-payments or deductibles for the remainder of the plan year. Only your monthly premium continues.

Married with both spouses in the plan

When your combined out-of-pocket expenses reach either $3,000 or 10% of your gross annual household income, whichever is less, you will no longer be required to pay co-payments or deductibles for the remainder of the plan year. Only your monthly premiums continue.

SINGLE OR MARRIED WITH ONE SPOUSE IN THE PLAN

PREMIUMS					DEDUCTIBLES AND CO-PAYMENTS						
Category	If you are single and your income is	-OR-	If you are married, with one spouse in the plan, and your income is	Your individual monthly premium is	Your individual quarterly deductible is	Your retail (up to a 30-day supply) co-payments are			Your mail service (up to a 90-day supply) co-payments are		
						Level 1	Level 2	Level 3	Level 1	Level 2	Level 3
1	$0 - $16,883		$0 - $22,786	$0	$0	$9	$23	$45	$18	$46	$80
2	$16,884 - $20,205		$22,787 - $27,270	$15	$25	$12	$30	$50	$24	$60	$100
3	$20,206 - $26,940		$27,271 - $36,360	$25	$50	$12	$30	$50	$24	$60	$100
4	$26,941 - $44,900		$36,361 - $60,600	$50	$100	$12	$30	$50	$24	$60	$100
5	$44,901 - and over		$60,601 - and over	$99	$125	$12	$30	$50	$24	$60	$100

MARRIED WITH BOTH SPOUSES IN THE PLAN

PREMIUMS			DEDUCTIBLES AND CO-PAYMENTS							
Category	If you are married, with both spouses in the plan, and your income is	Your individual monthly premium is	Your individual quarterly deductible is	Your retail (up to a 30-day supply) co-payments are			Your mail service (up to a 90-day supply) co-payments are		
				Level 1	Level 2	Level 3	Level 1	Level 2	Level 3
1	$0 - $22,786	$0	$0	$9	$23	$45	$18	$46	$80
2	$22,787 - $27,270	$12	$25	$12	$30	$50	$24	$60	$100
3	$27,271 - $36,360	$20	$50	$12	$30	$50	$24	$60	$100
4	$36,361 - $60,600	$40	$100	$12	$30	$50	$24	$60	$100
5	$60,601 - and over	$74	$125	$12	$30	$50	$24	$60	$100

How To Complete this Application Form

PLEASE:

Read the instructions on pages 6-10 carefully before completing the Application Form (pages i-iv).

- Remove pages i-iv marked “Application Form”.
- Answer all questions on the Application Form (pages i-iv).
- Submit the completed and signed Supplement A if you are designating an Authorized Representative.
- Submit the completed and signed Application Form with all required documentation to:

Prescription Advantage
P.O. Box 15153
Worcester, MA 01615-0153

Submission of this Application Form will result in your membership in Prescription Advantage upon approval.

If you have any questions about joining Prescription Advantage or need assistance completing this Application Form, please call Prescription Advantage customer service at:

1-800-AGE-INFO (1-800-243-4636), press “1”
TTY 1-877-610-0241 (toll free) for the deaf and hard of hearing.

This Application Form is available in other formats upon request.
Assistance for non-English speakers is available.

A General Information

Please be sure to provide complete and accurate information where requested. If you have a spouse who lives with you, you *must* complete the requested information for your spouse, even if he/she is not applying at this time. The following questions correspond to the questions found on the Application Form.

Question 1: Are you age 65 but not yet age 66?

Individuals age 65 can join at any time before their 66th birthday. If you answer "Yes" to this question, the Plan must receive your application prior to your 66th birthday.

If you answer "Yes", skip to Question 4.

If you answer "No" to this question, please continue with Question 2.

Question 2: Are you age 66 or older?

If you answer "No" to this question, skip to Question 3.

If you answer "Yes" to this question, your opportunity to join Prescription Advantage is limited and subject to the following conditions:

- Anyone age 66 and older can join only during open enrollment. In 2003, open enrollment is August 1 through August 31. If your application is received between August 1 and August 31, 2003, your application will be processed and, if complete, your benefits will begin on October 1, 2003.
- After August 31, 2003, you will have to wait until the next open enrollment period to apply, unless you qualify for an exception by answering "Yes" to any of Questions 2a, 2b, or 2c.

Question 2a: Have you moved to Massachusetts within the past 6 months?

If you answer "Yes" to this question, please indicate the date you moved. You have 6 months from the date you moved into Massachusetts to join. You *must* submit written documentation (such as a utility bill from your prior residence) with this application that demonstrates you were living in another state within the prior 6 months. The documentation must come from an independent commercial or government entity and must show a valid date as well as your previous address.

Question 2b: Have you involuntarily lost health care coverage within the past 6 months?

If you answer "Yes" to this question, please indicate the date you lost coverage. You have 6 months from the date you lost your health care coverage to join. You *must* submit written documentation (such as a copy of your termination letter) with this application that states you *involuntarily* lost health care coverage within the prior 6 months. The documentation must include the reason why the coverage was terminated.

Question 2c: Have you become ineligible for Medicaid within the past 6 months?

If you answer "Yes" to this question, please indicate the date you lost coverage. You have 6 months from the date you lost your Medicaid coverage to join. You *must* submit a copy of your termination letter with this application to demonstrate that you have become ineligible for Medicaid within the prior 6 months. The letter must include the date that the Medicaid coverage was terminated.

Questions 3 and 3a: Are you under age 65 with a disability?

Individuals under age 65 with a disability can join at any time.

If you answer "Yes" to Question 3 and 3a, you must meet income guidelines (not more than $16,883 for a single person, $22,786 for a two-person household) as well as the disability guidelines listed below.

To meet disability guidelines, individuals under age 65 must: receive SSDI or SSI benefits; receive Medicare benefits; have a certificate of blindness from the Massachusetts Commission for the Blind; or have a determination of disability from MassHealth or CommonHealth.

If you or your spouse (if your spouse is joining) is under age 65 and has a disability according to the above criteria, you *must* submit proof of the disability by attaching one of the following items:

- a copy of a current Social Security Administration award letter for SSDI or SSI benefits
- a copy of your Medicare card
- a certificate of blindness from the Massachusetts Commission for the Blind
- a copy of the determination of disability from MassHealth or CommonHealth (Medicaid)
- written verification of SSDI or SSI benefits signed by an authorized Social Security Claims Representative on Social Security letterhead

Question 4: Who is applying?

If you are single, or married and you are the only spouse joining at this time, check the box "You only". If you are married, and both you and your spouse are joining at this time, check the box "You and your spouse".

Question 5: Who lives in your household?

Members of your household include only: you, your spouse, if he/she is living with you, and any dependent children age 18 or younger who live with you. Household does not include any adults other than your spouse, any non-dependent children, or any dependent children who do not live with you. Please write the number of dependent children who live with you in the space provided. If your household is greater than two persons, please call Prescription Advantage customer service for rate schedule information.

Questions 6 and 7: Applicant and Spouse Information

Complete all the information requested for both you and your spouse, if he/she lives with you. Because we need to verify accurate *household* income information, which includes income information from your spouse, you must provide the information about your spouse even if he/she is not joining at this time.

Question 8: Are you a resident of Massachusetts?

Answer "Yes" if you are a Massachusetts resident. Answer "No" if you are not a Massachusetts resident.

Question 9: Do you receive prescription drug benefits through Medicaid?

Answer "Yes" if you are currently enrolled in a Medicaid program (MassHealth or CommonHealth) that provides prescription drug benefits. Answer "No" if you are not currently enrolled in a Medicaid program that provides prescription drug benefits.

Question 10: **Are you enrolled in Medicare?**

Answer "Yes" if you are currently enrolled in Medicare and provide your Medicare Claim # in the space provided.

Question 11: **Do you have any other health care coverage that includes prescription drug coverage?**

Answer "Yes" if you have any other health care coverage that pays for prescription drugs for you or your spouse and complete Section B, Prescription Drug Coverage. Answer "No" if you do not have any other health care coverage that pays for prescription drugs for you or your spouse, and skip to Section C, Income Verification.

B Prescription Drug Coverage

Complete this section fully if you or your spouse has any other health care coverage that pays for prescription drugs, including Medicare HMOs or any Medicare supplemental plans. If you have more than two, please include a separate page that lists the information requested in this section.

Please note: ***It is your responsibility to determine the relationship between your current prescription drug coverage and Prescription Advantage and decide what coverage (either or both) is right for you.***

C Income Verification

Please note: ***If you are under age 65 with a disability, you must provide documents to verify your gross annual household income. If you are under age 65 with a disability, skip to Question 14.***

Question 12: **Non-disclosure of income**

Answer “Yes” if you are age 65 or older and do not wish to disclose your income. By answering “Yes” you will be responsible for paying the highest premium, deductible and co-payment amounts. If you answer “Yes”, skip the rest of Section C and continue with Section D, Signature. **If you answer “No” to this question, please continue with Question 13.**

Question 13: **Disclosure of income**

Answer “Yes” if you are age 65 or older and would like to be considered for reduced premium, deductible and co-payment amounts based on your income.

Please note: ***If you answer “Yes” to this question, you must provide documents to verify your gross annual household income. To assist you in determining which documents you must provide with this application, please answer Questions 14 and 15 and read the accompanying instructions.***

Question 14: **Have <u>all</u> members of your household filed federal income tax returns within the past 2 years?**

If you answer "No" to this question, please continue with Question 15 for those members of your household who have not filed federal tax returns.

For all those in your household who have filed federal tax returns, please send copies of the most recently signed and filed federal tax return(s) with all schedules. For any members of your household who receive Social Security benefits, you *must* also send copies of their Social Security 1099 forms or annual award letters from the Social Security Administration for the same tax period.

If you answer "Yes," <u>do not</u> fill out the Income Table in Question 15, attach your federal income tax returns and social security documentation, and skip to Section D, Signature.

If you answer "Yes" to this question, you ***must*** send copies of your federal income tax returns for all household members ("household" as defined in Question 5) as verification of your gross annual household income. Please send copies of the most recently signed and filed federal income tax return(s) with all schedules for all members of your household. For any members of your household who receive Social Security benefits, you *must* also send copies of their Social Security 1099 forms or annual award letters from the Social Security Administration for the same tax period.

If your current income is substantially different from the income reflected on your federal income tax returns, please enclose an explanation letter and updated documents that reflect your current income. You may use any of the documents listed on page 10.

Question 15: **Income Table**

Complete this Income Table only for those members of your household who <u>do not</u> file federal income tax returns.

If you or any members of your household ("household" as defined in Question 5) have not filed a federal income tax return within the past two (2) years, complete the Income Table. For each type of income listed, indicate the amount you received in the past year, how much your spouse received in the past year, and how much your dependent children aged 18 or younger received in the past year. Please put an "X" in any box on the Income Table that you are leaving blank. For each type of income listed, you *must* include verification documents as listed on page 10.

You <u>must</u> submit verification of your income if you wish to be considered for reduced rates for premium, deductible or co-payment amounts, or if you are under age 65. You may use any of the documents listed on page 10.

If you are submitting copies of your federal tax return(s) they <u>must</u> be signed.

Question 15: **Income Table** ***(continued)***

Listed below are acceptable documents you can submit to verify your income if you do not file federal income tax returns, or if your current income is substantially different from the income reflected on your federal income tax returns.

These documents should reflect all household income received in the past year. If you have any questions, please call Prescription Advantage customer service at 1-800-AGE-INFO (1-800-243-4636) TTY 1-877-610-0241 (toll free) for the deaf and hard of hearing.

Social Security income. If you have Social Security income, please submit **a copy of one** of the following:

- Your annual benefit statement (SSA-1099 form)
- Your annual award letter from the Social Security Administration
- A benefit verification letter from the Social Security Administration detailing income received in the past 12 months

You may request a benefit verification letter by calling 1-800-772-1213, 7 a.m. – 7 p.m., Monday through Friday, or by contacting your local Social Security Administration Office.

Pension income. If you have pension income, please submit **a copy of one** of the following:

- Your annual benefit statement(s) (1099 form)
- A letter from your bank stating the annual amount of the direct deposit and the source
- Copies of two recent pension checks that can be annualized

Dividends and/or interest. If you have dividend or interest income, please submit **a copy of one** of the following:

- Your 1099 form(s)
- Your most recent year-end bank statement
- A letter from the bank stating the amount of interest earned in the previous year
- Your annual interest or dividend statement

Full or part-time wages. If you have employment income, please submit **a copy of one** of the following:

- Your W-2 form(s) or 1099 form(s)
- Two recent pay stubs, that can be annualized
- A statement from your employer stating your annual wages

Rental income. If you have rental income, please submit **a copy of one** of the following:

- The rental lease that can be used to determine your gross annual rental income
- A rental check that can be used to determine your gross annual rental income

Unemployment. If you have unemployment income, please submit **a copy of** the following:

- Your annual unemployment benefit statement (1099 form)

Capital gains. If you have capital gains income, please submit **a copy of one** of the following:

- Your 1099 form(s)
- A statement showing the full amount of the capital gain received

D Signature

Please read the signature page carefully, sign and date.

IMPORTANT – please remember if you have a spouse who lives with you, he/she must ALSO sign and date the signature page.

Please refer to instructions on pages 6-7 when answering the following questions.

A General Information

	You	Your Spouse
1. Are you age 65 but not yet age 66? *See page 6 for instructions.*	❑ Yes ❑ No	❑ Yes ❑ No
2. Are you age 66 or older? *If "Yes", answer the following three questions and see page 6 for instructions.*	❑ Yes ❑ No	❑ Yes ❑ No
a. Have you moved to Massachusetts within the past 6 months? Date: _____/_____/_____	❑ Yes ❑ No	❑ Yes ❑ No
b. Have you *involuntarily* lost health care coverage within the past 6 months? Date: _____/_____/_____	❑ Yes ❑ No	❑ Yes ❑ No
c. Have you become ineligible for Medicaid within the past 6 months? Date: _____/_____/_____	❑ Yes ❑ No	❑ Yes ❑ No
3. Are you under age 65 with a disability? *If "Yes", answer the following question and see page 7 for instructions.*	❑ Yes ❑ No	❑ Yes ❑ No
a. Do you work 40 hours or fewer per month, or not at all?	❑ Yes ❑ No	❑ Yes ❑ No

4. Who is applying? ❑ You only ❑ You and your spouse
See page 7 for instructions.

5. Who lives in your household? ❑ You only ❑ You and your spouse

❑ Dependent children aged 18 or younger. How many?_____
See page 7 for instructions.

6. Applicant Information *See page 7 for instructions.*

Last name	First name	MI
Primary address		
Mailing address (if different)		
Telephone number	Social Security number	Date of birth
Race (optional)	Sex ❑ Male ❑ Female	Preferred written language

Please refer to instructions on pages 7-8 when answering the following questions.

7. Spouse Information *See page 7 for instructions.*

If you have a spouse who lives with you, you must complete this section even if your spouse is not applying at this time.

Last name	First name	MI

Date of birth	Social Security number	Sex ❑ Male ❑ Female	Race (optional)

	You	Your Spouse
8. Are you a resident of Massachusetts? *See page 7 for instructions.*	❑ Yes ❑ No	❑ Yes ❑ No
9. Do you receive prescription drug benefits through Medicaid?(MassHealth or CommonHealth) *See page 7 for instructions.*	❑ Yes ❑ No	❑ Yes ❑ No
10. Are you enrolled in Medicare? *See page 8 for instructions.*	❑ Yes ❑ No	❑ Yes ❑ No
If "Yes", please provide the Medicare claim number.	Medicare claim # _____	Medicare claim # _____
11. Do you have any other health care coverage that includes prescription drug coverage? *See page 8 for instructions.*	❑ Yes ❑ No	❑ Yes ❑ No

If "Yes", please complete Section B, Prescription Drug Coverage and see page 8 for instructions.

B Prescription Drug Coverage *(Complete only if you have other health care coverage that includes prescription drugs.)* *See page 8 for instructions.*

Please note: It is your responsibility to determine the relationship between your current prescription drug coverage and Prescription Advantage and decide what coverage (either or both) is right for you.

ONE

Name of insurance company	Address	City	State	Zip

Name of policy holder	Policy number

TWO

Name of insurance company	Address	City	State	Zip

Name of policy holder	Policy number

Please refer to instructions on pages 8-10 when answering the following questions.

C Income Verification

12. I am age 65 or older and I do not wish to disclose my income. If I do not disclose my income, I understand I will be responsible for payment of the maximum premium, deductible and co-payment amounts.
See page 8 for instructions. ❑ Yes ❑ No

13. I am age 65 or older and I wish to be considered for reduced rates for premium, deductible and co-payment amounts based on my income.
See page 8 for instructions. ❑ Yes ❑ No

14. Have **all** members of your household filed federal income tax returns within the past 2 years? *See page 9 for instructions.* ❑ Yes ❑ No

If your income is substantially different from the income reflected on your federal tax returns, please submit an explanation letter and updated documents that reflect your current income. You may use any of the documents listed on page 10.

15. Income Table *See pages 9-10 for instructions.*
Complete only for those members of your household who have <u>not</u> filed federal income tax returns.
For acceptable income documentation, see page 10.

Type of income	Your annual income	+ Your spouse's annual income	+ Dependent children's annual income	= Combined annual income
1. Social Security Note: Include the Part B premium	$	$	$	$
2. Pensions	$	$	$	$
3. Dividends and/or interest	$	$	$	$
4. Employment income	$	$	$	$
5. Rental income	$	$	$	$
6. Capital gains	$	$	$	$
7. Other: _____ please specify	$	$	$	$
8. Other: _____ please specify	$	$	$	$
9. **Total income**	$	$	$	$

D Signature *See page 10 for instructions.*

Please read the following statements and sign and date the bottom of the page. Because we request accurate verification of household income, which includes spouse's income, your spouse **must** sign too if he/she lives with you, even if he/she is not joining at this time.

I understand that the information provided for the purpose of determining eligibility or for coordinating benefits is subject to verification.

Prescription Advantage shall maintain the confidentiality of my personal information to the extent required by applicable law and regulation.

I understand that I must notify Prescription Advantage in writing within fifteen business days of any changes to the information submitted on this application.

By signing and submitting this application, I certify that I want to join Prescription Advantage and understand that I will be enrolled in the Plan upon the approval of this Application Form.

I understand and agree to abide by all policies, procedures and regulations of Prescription Advantage.

Under the penalties of perjury, I declare that the information submitted on this form and any accompanying or supplemental information is true, complete and correct to the best of my knowledge and belief.

If you are acting on behalf of someone who is unable to complete this form because of a physical or mental condition, by signing this form, you are declaring that the information submitted and any accompanying or supplemental information is true, complete and correct to the best of your knowledge and belief.

X _____ Date: _____
Signature of applicant (or applicant's designee if the applicant is unable to complete this form)

X _____ Date: _____
Signature of applicant's spouse (or spouse's designee if the spouse is unable to complete this form)

The applicant's spouse **must** sign, if he/she lives with the applicant, even if he/she is not joining at this time.

This application cannot be processed unless both applicant and spouse sign the form.

AUTHORIZED REPRESENTATIVE

This form allows you to designate someone to make decisions for your household regarding Prescription Advantage as well as have access to your Protected Health Information. Protected Health Information includes all enrollment, eligibility, billing, and prescription drug claims information.

If you want to grant someone the authority to act on behalf of you (and your spouse) please read the detailed information below, fill out the necessary information, and sign where indicated. If you and your spouse are both applying and you want someone to act on your behalf, you must both agree to have an Authorized Representative designated for your household. You must both agree to designate the same Authorized Representative, and you must both sign this form.

An Authorized Representative has the authority to make decisions for you (and your spouse) about your Plan membership(s) and participation. For example, a member who has designated an Authorized Representative can only terminate membership if the Authorized Representative agrees.

Prescription Advantage will send your approval letter(s), identification card(s), member notices, monthly bills, and all other Plan correspondence to your Authorized Representative instead of to you.

By completing this form, you authorize Prescription Advantage to share all verbal and written communication and personal data with your designated Authorized Representative.

You are not required to designate an Authorized Representative. If you <u>do not</u> wish to have an Authorized Representative, do not complete this supplement.

If you would like to designate an Authorized Representative, please complete and sign the reverse side of this form and return it with your application.

If you have any questions about Authorized Representatives or how to complete this form, please call Prescription Advantage customer service at 1-800-AGE-INFO (1-800-243-4636) TTY 1-877-610-0241 (toll free) for the deaf and hard of hearing.

Prescription Advantage

SUPPLEMENT A

Authorization

I (We) designate the following person to be my (our) Authorized Representative and authorize Prescription Advantage to release my (our) Protected Health Information to:

Name of applicant/member:	Name of spouse	Telephone number	
Name of Authorized Representative (Please print):		Telephone number	
Address	City	State	Zip

If the designated Authorized Representative is someone who has legal authority to make decisions on your behalf (such as a legal guardian or a person with power of attorney), please include documentation to verify this status.

By signing this form to designate an Authorized Representative, I am indicating that:

- I understand this authorization covers my Protected Health Information, including all enrollment, eligibility, billing, and prescription drug claims information.
- I understand that all Plan correspondence will go to my Authorized Representative instead of to me. This includes approval letter(s), identification card(s), member notices, monthly bills, and all other Plan correspondence.
- I understand that this designation will continue as long as I am a member of Prescription Advantage unless I cancel or change this permission. I may do this at any time by sending a letter to: Prescription Advantage, PO Box 15153, Worcester, MA 01615-0153.
- I understand that even if I cancel or change this permission, Prescription Advantage cannot take back information that has already been released.
- I understand that after Prescription Advantage releases my information to my Authorized Representative, it may no longer be protected by privacy law, and may be given out again by the person to whom the information was released.
- I understand that my actions to designate, change, or remove an Authorized Representative will not impact my ability to receive benefits from Prescription Advantage.

X _____ Date: _____
Signature of applicant (or designee if the applicant is unable to complete this form)

X _____ Date: _____
Signature of spouse (or designee if the spouse is unable to complete this form)

X _____ Date: _____
Signature of Authorized Representative

Prescription Advantage

CHECKLIST

Did you remember to:

- ❑ Provide and attach proof of income if you or your spouse is applying for reduced rates?
- ❑ Provide and attach proof of income and disability if you or your spouse is under age 65 and has a disability?
- ❑ Sign and date the Application Form?
- ❑ Provide information about your spouse, including his/her signature, if he/she lives with you, even if your spouse is not joining at this time?
- ❑ Complete, sign and include the Supplement A if you wish to designate an Authorized Representative?
- ❑ Make a copy of the Application Form for your records?
- ❑ Determine and apply the appropriate postage?

If you have any questions about joining Prescription Advantage or need assistance completing this Application Form, please call 1-800-AGE-INFO (1-800-243-4636), TTY 1-877-610-0241 (toll free) for the deaf and hard of hearing.

Please send completed Application Form with required documentation to:

Prescription Advantage
P.O. Box 15153
Worcester, MA 01615-0153

Insufficient postage may delay or prevent the receipt of your application.

Administered by the Massachusetts Executive Office of Elder Affairs

Prescription Advantage

P.O. Box 15153 • Worcester, MA 01615-0153
1-800-AGE-INFO (1-800-243-4636) • www.800ageinfo.com
TTY 1-877-610-0241 (toll free) for the deaf and hard of hearing

English	Important! Please have this notice translated immediately.
Armenian	Կարևոր է.– Խնդրվում է այս ծանուցումը անմիջապես թարգմանեք
Chinese	务请注意！请立即翻译本通知。
Cambodian	សំខាន់ណាស់! សូមរកអ្នកណាម្នាក់ ឲ្យបកប្រែខិតប័ណ្ណនេះ ជាមួយរំពេច
French	Important ! Faites traduire cette notice immédiatement.
Greek	Προσοχη! Παρακαλω μεταφραστε αυτο το μυνημα αμεσως.
Haitian	Enpòtan! Tanpri fè tradwi anons sa a imedyatman.
Italian	Importante! Far tradurre immediatamente questo avviso.
Laotion	"ສຳຄັນທີ່ສຸດ! ກະຣຸນາແປຄຳເຕືອນອັນນີ້ທັນທີທັນໃດ"
Polish	Ważne! Proszę przetłumaczyć tę uwagę natychmiast.
Portuguese	Importante! Favor mandar traduzir este folheto imediatamente.
Russian	Крайне важно! Пожалуйста, переведите это объявление немедленно.
Spanish	¡Importante! Por favor traduzca este folleto inmediatamente.
Vietnamese	Quan trọng! Xin vui lòng cho dịch tờ thông báo này ngay.

Revised July 2003